DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

NOTICE OF FINAL RULEMAKING

The Commissioner of the Department of Insurance, Securities and Banking, pursuant to the authority set forth in Section 12 of the Long-Term Care Insurance Act of 2000, effective May 23, 2000, D.C. Law 13-121, D.C. Official Code § 31-3601 *et seq.* (2002), as amended by the Long-Term Care Conformity Amendment Act of 2002, effective October 10, 2002, D.C. Law 14-190 ("Act"), gives notice of his intent to add a new Chapter 26, entitled Long Term Care Insurance, to Title 26 of the D.C. Municipal Regulations (Insurance), in not less than thirty days from the date of publication of this notice in the *District of Columbia Register*. The purpose of this new chapter is to implement the Act to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverage, and to facilitate flexibility and innovation in the development of long-term care insurance. The Notice of Proposed Rulemaking was published in the *D.C. Register* at 52 DCR 6388 (July 8, 2005)). No comments were received.

Title 26 DCMR (Insurance) is amended by adding a new Chapter 26, Long Term Care Insurance.

2600 Applicability and Scope

2600.1 Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in the District of Columbia on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

2600.2 Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, under the following conditions:

a. If the benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

b. If the disability income policy is advertised, marketed or offered as insurance for long-term care services; or

c. If benefits under the policy may commence after the policyholder

has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

2601 Exceptional Increases

2601.1 "Exceptional increase" - only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified for the following reasons:

(a) Due to changes in laws or regulations applicable to long-term care coverage in the District of Columbia; or

(b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

2601.2 Except as provided in section 2617, exceptional increases are subject to the same requirements as other premium rate schedule increases.

2601.3 The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

2601.4 The Commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

2602 Policy Practices and Provisions

2602.1 The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of section 2605 of this regulation.

2602.2 A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable" provisions.

2602.3 The term "guaranteed renewable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

2602.4 The term "noncancellable" shall be used only when the insured has the

right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

2602.5 The term "level premium" shall only be used when the insurer does not have the right to change the premium.

2602.6 In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

2602.7 A policy shall not be delivered or issued for delivery in the District of Columbia as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except for the following reasons:

(a) Preexisting conditions or diseases;

(b) Mental or nervous disorders; however, this shall not permit exclusion or limitation or benefits on the basis of Alzheimer's Disease.

(c) Alcoholism and drug addiction;

(d) Illness, treatment or medical condition arising out of:

(1) War or act of war (whether declared or undeclared);

(2) Participation in a felony, riot or insurrection;

(3) Service in the armed forces or units auxiliary thereto;

(4) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

(5) Aviation (this exclusion applies only to non-fare-paying passengers).

(e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate

family and services for which no charge is normally made in the absence of insurance;

(f) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(g) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(h) This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

2602.8 Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

2602.9 Continuation or Conversion is as follows:

(a) Group long-term care insurance issued in the District of Columbia on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(c) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six (6) months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(d) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except in the following instance:

(1) Where termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) Where the terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(a) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(b) The premium for which is calculated in a manner consistent with the requirements of paragraph (f) of this section.

(h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(k) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

2602.5 If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy shall not do the following:

(a) Result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(b) Vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

2602.6 The premium charged to an insured shall not increase due to either of the following:

(1) The increasing age of the insured at ages beyond sixty-five (65); or

(2) The duration the insured has been covered under the policy.

2602.7 The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under section 2622, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

2602.8 A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under section 2623, the initial annual premium shall be based on the reduced benefits.

2602.9 In the case of group long term care insurance defined in D.C. Official Code §31-3601(4), any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if the following is present:

(a) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality

of individually identifiable information and privileged information is maintained.

(c) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee.

2602.10 The insurer shall make available, upon request of the Commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

2602.11 No long -term insurance policy delivered or issued for delivery in the District of Columbia shall use the term set forth herein or in Section 2699, unless the terms are defined in the policy and the definitions satisfy the following requirements of this section.

2602.12 "Skilled nursing care," "intermediate care," "personal care," "home care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

2602.13 All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

2603 Unintentional Lapse

2603.1 Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(a) No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide

space clearly designated for listing at least one person. The designation shall include each *person's full name and home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less than once every two (2) years.

(b) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subsection 2604.1(a) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(c) No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subsection 2603.1(a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

2603.2 In addition to the requirement in subsection 2603.1, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more

stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

2604 Required Disclosure Provisions

2604.1 Individual long-term care insurance policies shall contain a renewability provision as follows:

(a) The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

2604.2 Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

2604.3 A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

2604.4 If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

2604.5 A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in D.C. Official

Code § 31-3605 shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

2604.6 With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

2604.7 Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

2604.8 A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in subsection 2625.5 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

2604.9 A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in subsection 2626.5 that the policy is not intended to be a qualified long-term care insurance contract.

2605 Required Disclosure of Rating Practices to Consumers

2605.1 Except as provided in subsection 2605.2, this section applies to any long-term care policy or certificate issued in the District of Columbia on or after six (6) months after adoption of the amended regulation.

2605.2 For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in D.C. Official Code § 31- 4601(4), which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following twelve (12) months after

adoption of the amended regulation.

2605.3 Other than policies for which no applicable premium rate or rate schedule increase can be made, insurers shall provide all of the following information in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at this time, in which case, an insurer shall provide all of the following information in this section to the applicant no later than at the time of delivery of the policy or certificate:

(a) A statement that the policy may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(d) A general explanation for applying premium rate or rate schedule adjustments that shall include the following:

(1) A description of when premium rate or rate schedule adjustments will be effective (e.g. next anniversary date or next billing date); and

(2) The right to a revised premium rate or rate schedule as provided in paragraph (b) if the premium rate or rate schedule is changed;

(e) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for the District of Columbia or any other jurisdiction that, at a minimum which identifies the following:

(1) The policy forms for which premium rates have been increased;

(2) The calendar years when the form was available for purchase; and

(3) The amount or percent of each increase, expressed as a percentage of the premium rate prior to the increase, or expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;

(f) The insurer may provide in a fair manner, additional explanatory information related to the rate increase.

2605.4 An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

2605.5 If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four (24) month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure, However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subparagraph (e) of section 2605.3.

2605.6 If the acquiring insurer in subsection 2605.2(e)(4) above files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subsection 2605.2(e)(4), the acquiring insurer shall make all disclosures required by Section or subsection 2605.2 (e), including disclosure of the earlier rate increase referenced in subsection 2605.2(e).

2605.7 An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subsections 2605.2 (a) and 2605.2 (e). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

2605.8 An insurer shall use the forms in Appendices B and F to comply with the requirements of subsections 2605.1 and 2605.2 of this section.

2605.9 An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five (45) prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection 2605 when the rate increase is implemented.

2606 Initial Filing Requirements

2606.1 The requirement of section 2606 applies to any long-term care policy issued in the District of Columbia on or after six (6) months after adoption of these rules.

2606.2 An insurer shall provide the following information to the Commissioner (thirty (30) days) prior to making a long-term care insurance form available for sale:

(a) A copy of the disclosure documents required in section 2606; and

(b) An actuarial certification consisting of the following:

(1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(4) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include the following:

(a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(b) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(c) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(d) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this

does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Commissioner may request a demonstration under subsection 2606.3 based on a standard age distribution; and

(5) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(6) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

2606.3 The Commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

2606.4 In the event the Commissioner asks for additional information under this provision, the period in subsection 2606.1 does not include the period during which the insurer is preparing the requested information.

2607 Prohibition Against Post-Claims Underwriting

2607.1 All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

2607.2 If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

2607.3 If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise

be denied, then the policy or certificate shall not be rescinded for that condition.

2607.4 Except for policies or certificates that are guaranteed issue the following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

2607.5 The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

2607.6 Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

(a) A report of a physical examination;

(b) An assessment of functional capacity;

(c) An attending physician's statement; or

(d) Copies of medical records.

2607.7 A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

2607.8 Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the Commissioner of the

Department of Insurance and Securities Regulation in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

2608 Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies

2608.1 A long-term care insurance policy or certificate that provides benefits for home health care or community care services, shall not limit or exclude these benefits by any of the following means:

(a) Requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(b) Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered.

(c) Limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(e) Excluding coverage for personal care services provided by a home health aide;

(f) Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(g) Requiring that the insured or claimant have an acute condition before home health care services are covered;

(h) Limiting benefits to services provided by Medicare-certified agencies or providers; or

(i) Excluding coverage for adult day care services.

2608.2 A long-term care insurance policy or certificate, that provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under

the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

2608.3 Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

2609 Requirement to Offer Inflation Protection

2609.1 No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

2609.2 Where the policy is issued to a group, the required offer in subsection 2609.1 shall be made to the group policyholder; except, if the policy is issued to a group defined in D.C. Official Code § 31-3601(4), other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

2609.3 The offer in subsection 2609.1 shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

2609.4 Insurers shall include the following information in or with the outline of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period; and

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

2609.5 An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of disclosures under section 2609.

2609.6 Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

2609.7 An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

2609.8 Inflation protection as provided in section 2610 shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection."

2610 Requirements for Application Forms and Replacement Coverage

2610.1 Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used.

2610.2 With regard to a replacement policy issued to a group defined by D.C. Official Code § 31-3601(4), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement:

(a) "Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?",

(b) "Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?"

(1) "If so, with which company?"

(2) "If that policy lapsed, when did it lapse?"

(c) "Are you covered by Medicaid?";and

(d) "Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?".

2610.3 Agents shall list any other health insurance policies they have sold to the applicant, including the following:

(a) Policies sold that are still in force; and

(b) Policies sold in the past five (5) years that are no longer in force.

2610.4 Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. D.C. law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your

medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent or Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant " was delivered to me on:

_____ _____

(Applicant's Signature) (Date)

2610.5 Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits

under the new policy, whereas a similar claim might have been payable under your present policy.

2. District of Columbia law provides that you replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) or similar benefits to the extent such time was spent (depleted) under the original policy.

3. If your are replacing existing long-term care insurance coverage, you may wish to secure the advise of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

2610.6 Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

2610.7 Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with replacement requirements. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

2611 Reporting Requirements

2611.1 Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

2611.2 Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by subsection 2611.1 above.

2611.3 Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

2611.4 Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

2611.5 Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

2611.6 Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)

2611.7 The following terms are defined for purposes of this section as follows:

(a) "Policy" - only long-term care insurance;

(b) Subject to paragraph (c), "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" - the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" - on a statewide basis.

2611.8 Reports required under this section shall be filed with the Commissioner.

2612 Licensing

2612.1 A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by D.C. Official Code § 31-803.

2613 Discretionary Powers of Commissioner

2613.1 The Commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding of the following:

(a) The modification or suspension would be in the best interest of the insureds;

(b) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(c) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(d) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(e) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

2614 Reserve Standards

2614.1 When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with D.C. Official Code § 31-4701. Claim reserves shall also be established in the case when the policy or rider is in claim status.

2614.2 Reserves for policies and riders subject to this section should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The

calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefit. However, in no event shall the reserves for the long-term care benefit, and life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

2614.3 In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(a) Definition of insured events;

(b) Covered long-term care facilities;

(c) Existence of home convalescence care coverage;

(c) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Premium waiver provision;

(g) Renewability;

(h) Ability to raise premiums;

(i) Marketing method;

(j) Underwriting procedures;

(k) Claims adjustment procedures;

(l) Waiting period;

(m) Maximum benefit;

(n) Availability of eligible facilities;

(o) Margins in claim costs;

(p) Optional nature of benefit;

(q) Delay in eligibility for benefit;

(r) Inflation protection provisions; and

(s) Guaranteed insurability option.

2614.4 Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

2614.5 When long-term care benefits are provided other than as in this section, reserves shall be determined in accordance with D.C. Official Code § 31-4701.

2615 Loss Ratio

2615.1 This section shall apply to all long-term care insurance policies or certificates except those covered under sections 2606 and 2616.

2615.2 Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:

(a) Statistical credibility of incurred claims experience and earned premiums;

(b) The period for which rates are computed to provide coverage;

(c) Experienced and projected trends;

(d) Concentration of experience within early policy duration;

(e) Expected claim fluctuation;

(f) Experience refunds, adjustments or dividends;

(g) Renewability features;

(h) All appropriate expense factors;

(i) Interest;

(j) Experimental nature of the coverage;

(k) Policy reserves;

(l) Mix of business by risk classification; and

(m) Product features such as long elimination periods, high deductibles and high maximum limits.

2615.3 Subsection 2615.2 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of D.C. Official Code § 31-4705.02;

(c) The policy meets the disclosure requirements of D.C. Official Code § 31-3606;

(d) Any policy illustration meets the applicable requirements of the National Association of Insurance Commissioners Life Insurance Illustrations Model Regulation; and

(e) An actuarial memorandum is filed with the District of Columbia Department of Insurance and Securities Regulation that includes the following:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include a percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives.

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

2616 Premium Rate Schedule Increases

2616.1 This section shall apply as follows:

(a) Except as provided in paragraph (b), this section applies to any long term care policy or certificate issued in the District of Columbia on or after six (6) months after adoption of these rules.

(b) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in D.C. Official Code § 31-3601(4), which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary twelve (12) months after adoption of the amended regulation.

2616.2 An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Commissioner at least (thirty (30) days) prior to the notice to the policyholders and shall include the following:

(a) Information required by section 2603 ;

(b) Certification by a qualified actuary that:

(1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increase are anticipated;

(2) The premium rate filing is in compliance with the provisions of this section;

(c) An actuarial memorandum justifying the rate schedule change request that includes the following:

(1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(2) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(3) The projections that include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(a) The projections shall demonstrate compliance with subsection 2607.3; and

(b) For exceptional increases, the projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(c) In the event the Commissioner determines as provided in subsection 2600.1(d) that offsets may exist, the insurer shall use appropriate net projected experience;

(4) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(5) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(6) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(7) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and

(e) Sufficient information for review (and approval) of the premium rate schedule increase by the Commissioner.

2616.3 All premium rate schedule increase shall be determined in accordance with the following requirements:

(a) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increase shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(1) The accumulated value of the initial earned premium times fifty-eight (58%);

(2) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(3) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

(4) Eighty-five (85%) of the present value of future projected premiums not in subparagraph (3) on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in paragraph (b) (2) and (4) will also include seventy percent (70%) for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the National Association of Insurance Commissioners (NAIC) Health Reserves Model Regulation Appendix A, Section IIA. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

2616.4 For each rate increase that is implemented, the insurer shall file for review and approval by the Commissioner updated projections, as defined in subsection 2616.2(c)(1), annually for the next three (3) years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection 2616.11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

2616.5 If any premium rate in the revised premium rate schedule is greater than 200 percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection 2616.2(c)(1), shall be filed for review and approval by the Commissioner every five (5) years following the end of the required period in subsection 2616.4. For group insurance policies that meet the conditions in subsection 2616.11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

2616.6 If the Commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection 2616.3, the Commissioner may require the insurer to implement any of the following:

(1) Premium rate schedule adjustments; or

(2) Other measures to reduce the difference between the projected and actual experience.

2616.7 In determining whether the actual experience adequately matches the

projected experience, consideration should be given to subsection 2616.2(c)(5), if applicable.

2616.8 If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file the following:

(a) A plan, subject to Commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in subsection 2616.9 of this section; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection 2616.3 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in subsections 2616.3(b)(1) and (3).

2616.9 For a rate increase filing that meets the following criteria, the Commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) The rate increase is not the first rate increase requested for the specific policy form or forms;

(2) The rate increase is not an exceptional increase; and

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(a) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(b) The offer shall include the following:

(1) Be subject to the approval of the Commissioner;

(2) Be based on actuarially sound principles, but not be based on attained age; and

(3) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(c) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of the following:

(1) The maximum rate increase determined based on the combined experience; and

(2) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

2616.10 If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of subsection 2616.9, prohibit the insurer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five (5) years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

2616.11 Subsections 2616.1 through 2616.10 shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subsection 2616.2, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not

to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements of:

(1) D.C. Official Code § 31-4705.02; and

(2) D.C. Official Code §31-4705.03;

(c) The policy meets the disclosure requirements of D.C. Official Code § 31-3606;

(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements of the following:

(1) Policy illustrations as required by D.C. Official Code § 31-4703; and

(2) Disclosure requirements as required by D.C. Code § 31-4703.

(e) An actuarial memorandum is filed with the Department of Insurance and Securities Regulation that includes the following:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

2616.12 Subsections 2616.6 and 2616.9 shall not apply to group insurance policies as defined in D.C. Official Code § 31-3601(4) where:

(a) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer;

(b) The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

2617 Filing Requirement

2617.1 Prior to an insurer or similar organization offering group long-term care insurance to a resident of the District of Columbia pursuant to D.C. Official Code § 31-3604, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in the District of Columbia.

2618 Filing Requirements for Advertising

2618.1 Every insurer, health care service plan or other entity providing long-term care insurance or benefits in the District of Columbia shall provide a copy of any long-term care insurance advertisement intended for use in the District of Columbia whether through written, radio or television medium to the Commissioner of the Department of Insurance and Securities Regulation of the District of Columbia for review or approval by the Commissioner to the extent it may be required under District of Columbia

law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

2618.2 The Commissioner may exempt from these requirements any advertising form or material when, in the Commissioner's opinion, this requirement may not be reasonably applied.

2619 Standards for Marketing

2619.1 Every insurer, health care service plan or other entity marketing long-term care insurance coverage in the District of Columbia, directly or through its producers, shall proceed as follows:

(a) Establish marketing procedures and agent training requirements to assure the following:

(1) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

(2) Excessive insurance is not sold or issued;

(b) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer. This policy may not cover all of the cost associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations." ;

(c) Provide copies of the disclosure forms required in subsection 2616.7 (Appendices B and F) to the applicant;

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required;

(e) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with subsection 2619.1;

(f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the Commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that the program is available and the name, address and telephone number of the program.;

(g) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to subsection 2602.1(c) of this regulation; and

(h) Provide an explanation of contingent benefit upon lapse provided for in subsection 2622.4(c).

2619.2 The following acts and practices are prohibited:

(a) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer;

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance;

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company; and

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

2619.3 With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in D.C. Official Code § 35-4901, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by such associations to ensure that members

of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold, as follows:

(a) The insurer shall file with the Department of Insurance and Securities Regulation the following material:

(1) The policy and certificate;

(2) A corresponding outline of coverage; and

(3) All advertisements requested by the Department of Insurance and Securities Regulation.

(b) The association shall disclose the following in any long-term care insurance solicitation:

(1) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(2) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(c) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(d) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(e) The association shall also do the following:

(1) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(2) Actively monitor the marketing efforts of the insurer and its agents; and

(3) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

(4) Subparagraphs (1) through (3) shall not apply to qualified long-term care insurance contracts.

(f) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the Department of Insurance and Securities Regulation the information required in this subsection.

(g) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

(h) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice.

2620 Suitability

2620.1 This section shall not apply to life insurance policies that accelerate benefits for long-term care.

2620.2 Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall perform the following:

(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(b) Train its agents in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

2620.3 To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

(a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

2620.4 The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subsection 2620.3 above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Commissioner.

2620.5 A completed personal worksheet shall be returned to the issuer prior the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

2620.6 The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

2620.7 The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

2620.8 Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

2620.9 At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.

2620.10 If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant had declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant had declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the

applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

2620.11 The issuer shall report annually to the Commissioner the total number of applications received from residents of the District of Columbia, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

2621 Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

2621.1 If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

2622 Nonforfeiture Benefit Requirement

2622.1 This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

2622.2 To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of D.C. Official Code § 31-3610:

(a) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection 2609.5; and

(b) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

2622.3 If the offer required to be made under D.C. Official Code § 31-3610 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

2622.4 After rejection of the offer required under D.C. Official Code § 31-3610, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

2622.5 In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

2622.6 The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase. Triggers are as follows:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%

83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

2622.7 On or before the effective date of a substantial premium increase as defined in section 2622.6 above, the insurer shall:

(a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(b) Offer to convert to a paid-up status with a shortened benefit period in accordance with the terms of subsection 2609.5. This option may be elected at any time during the 120-day period referenced in subsection 2609.4 (c); and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in subsection 2609.4 (c) shall be deemed to be the election of the offer to convert in paragraph (b) above.

2622.8 Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described as follows:

(a) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50), and

(b) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increase thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (c).

(c) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened

benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection 2609.6.

(d) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(e) Notwithstanding the above paragraph, with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(1) The end of the tenth year following the policy or certificate issue date; or

(2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(f) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

2622.9 All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

2622.10 There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

2622.11 The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

(a) Except as provided in paragraph (b), the provisions of this section apply to any long-term care policy issued in the District of Columbia on or after the effective date of this amended regulation.

(b) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in D.C. Code § 35-4901, which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

2622.12 Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of section 2606 treating the policy as a whole.

2622.13 To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection 2609.4 (c), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

2622.14 A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(a) The nonforfeiture provision shall be appropriately captioned;

(b) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Commissioner for the same contract form; and

(c) The nonforfeiture provision shall provide at least one of the following:

(1) Reduced paid-up insurance;

(2) Extended term insurance;

(3) Shortened benefit period; or

(4) Other similar offerings approved by the Commissioner.

2623 Standards for Benefit Triggers

2623.1 A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

2623.2 Activities of daily living shall include at least the following as defined in Section 2601 and in the policy:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting; and

(7) Transferring.

2623.3 Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subsection 2623.2, as long as they are defined in the policy.

2623.4 An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements in subsections 2623.1 and 2623.2.

2623.5 For purposes of this section the determination of a deficiency shall not be more restrictive than the following:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(b) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

2623.6 Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

2623.7 Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

2623.8 The requirements set forth in this section shall be effective 12 months after adoption of this provision and shall apply as follows:

(a) Except as provided in paragraph (b), the provisions of this section apply to a long-term care policy issued in the District of Columbia on or after the effective date of the amended regulation, and

(b) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in D.C. Official Code § 31-3601(4) that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

2624 Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts

2624.1 For purposes of this section the following definitions apply:

(a) "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as follows:

(1) As being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or

(2) As requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(c) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

(d) "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

(e) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

2624.2 A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2624.3 A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

2624.4 Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection 2624.3 shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

2624.5 Certifications required pursuant to subsection 2624.3 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period or a least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

2624.6 Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

2625 Standard Format Outline of Coverage

2625.1 This section of the regulation implements, interprets and makes specific, the provisions of D.C. Official Code § 31-3606 in prescribing a standard format and the content of an outline of coverage.

2625.2 The outline of coverage shall be a free-standing document, using no smaller than ten-point type.

2625.3 The outline of coverage shall contain no material of an advertising nature.

2625.4 Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

2625.5 Use of the test and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

2625.6 Format for outline of coverage is as follows:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] was issued in the [indicate jurisdiction in which group policy was issued.

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not

an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement: RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right , subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue

this policy as long as you pay your premiums on time. [Company Name] cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return - "free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic , preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

2626 Requirement to Deliver Shopper's Guide

2626.1 A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners (NAIC), or a guide developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

2626.2 In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2626.3 In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

2626.4 Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under D.C. Official Code § 31-3606.

2627 Penalties

2627.1 In addition to any other penalties provided by the laws of the District of Columbia any insurer and any agent found to have violated any requirement of the District of Columbia relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for

each policy involved in the violation or up to $10,000, whichever is greater.

2699 Definitions

2699.1 "Activities of daily living" - at least bathing, continence, dressing, eating, toileting and transferring.

2699.2 "Acute condition" - that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

2699.3 "Adult day care" - a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

2699.4 "Bathing" - washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

2699.5 "Cognitive impairment" - a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

2699.6 "Continence" - the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

2699.7 "Dressing" - putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

2699.8 "Eating" - feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

2699.9 "Hands-on assistance" - physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

2699.10 "Home health care services" - medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

2699.11 "Incidental" - as used in subsection 2616.10, is the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

2699.12 "Medicare" - "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," of words of similar import.

2699.13 "Mental or nervous disorder" - Not defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

2699.14 "Personal care" - the provision of hands-on services to assist an individual with activities of daily living.

2699.15 "Qualified actuary" - a member in good standing of the American Academy of Actuaries.

2699.16 "Similar policy forms" - all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in D.C. Official Code § 31-3601 are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

2699.17 "Toileting" - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

2699.18 "Transferring" - moving into or out of a bed, chair or wheelchair.

DEPARTMENT OF PUBLIC WORKS

NOTICE OF FINAL RULEMAKING

The Director, D.C. Department of Public Works, pursuant to the authority set forth in section 2(c) of the District of Columbia Solid Waste Disposal Act of 1989, effective July 15, 1989 (D.C. Law 8-16; 36 DCR 4155) and Mayor's Order 2005-123, dated August 23, 2005, hereby gives notice of final action to adopt the following rules on November 29, 2005. The Department of Public Works published a Notice of Proposed Rulemaking on October 7, 2005, at 52 DCR 8960. In addition, the proposed rules were submitted to the Council of the District of Columbia on September 20, 2005 for a forty-five day period of review. The Council of the District of Columbia took no action to disapprove the proposed rules during that review period and they were deemed approved on November 28, 2005.

The Department of Public Works did not receive any public comments on the proposed rules and the final rules are identical to the proposed rules. These final rules will become effective upon publication of this notice in the *D.C. Register.*

Chapter 7 of Title 21, DCMR, is amended as follows:

Section 719.6 is amended to read as follows:

719.6 The following fee-setting formula is established for the disposal of each ton of construction and demolition debris: Solid Waste Disposal Fee for Construction and Demolition Debris + Solid Waste Disposal Fee + Special Handling Costs + Recycling Surcharge

Section 720.5 is amended to read as follows:

720.5. The applicable fees for the disposal of construction and demolition debris at the waste-handling facilities shall be seventy dollars ($70.00) for each ton disposed; Provided, that a minimum fee of thirty-five dollars ($35.00) shall be imposed on each load weighing one thousand pounds (1,000 lbs.) or less.

Section 720.8 is amended to read as follows:

720.8 The applicable fees for the disposal of each ton of solid waste at the waste-handling facilities, excluding those wastes specified in § 720.5, 720.6, and 720.7, shall be fifty dollars ($50.00) for each ton disposed; provided, that a minimum fee of twenty-five dollars ($ 25.00) shall be imposed on each load weighing one-thousand pounds (1,000 lbs.) or less.

Section 720.9 is amended to read as follows:

720.9 The waste reduction and recycling surcharge shall be one dollar ($ 1.00) for each ton of solid waste disposed of at the waste-handling facilities.

Section 720.10 is repealed.

Section 721.1 is amended to read as follows:

721.1 A solid waste collector who disposes of solid waste at a disposal facility owned by, operated by, or under contract with the District shall pay its disposal fees in advance by certified check or credit card, or by establishing an escrow account with a financial institution for monthly drawdowns by the District to pay for the collector's solid waste disposal fees. The escrow account shall maintain a balance equivalent to sixty (60) days of estimated disposal fees. Estimated disposal fees shall be based on the average of the solid waste collector's disposal cost from the preceding six (6) month period. If the disposal cost information for the preceding six (6) month period is not available, the Mayor shall reasonably determine the balance to be maintained in the escrow account. All escrow accounts shall be reconciled within five (5) business days after the date on which the solid waste disposal collector is notified of any deficiency in an escrow account. If the escrow account is not reconciled within five (5) business days, the Mayor shall impose a five percent (5%) penalty based on the amount due in the escrow account.

Section 721.2 is repealed.